

PATIENT FORM

EYE HISTORY

Date of Last Eye Exam _____

Currently Wear Glasses? _____

Currently Wear Contacts? _____

Reason for Today's Visit _____

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Cataracts	yes	no	family
Crossed Eye	yes	no	family
Glaucoma	yes	no	family
LASIK or RK	yes	no	family
Lazy Eye	yes	no	family
Macular Degeneration	yes	no	family
Retinal Detachment	yes	no	family

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

Blurry Vision *near or distance*

Burning

Discharge

Double Vision

Dryness

Excess Tearing/Watering

Eye Infection

Eye Pain or Soreness

Floaters or Spots

Halos

Headaches

Itching

Light Flashes

Light Sensitivity

Redness

Sandy or Gritty Feeling

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

AIDS/HIV	yes	no	family
Allergies	yes	no	family
Arthritis	yes	no	family
Asthma	yes	no	family
Blood/Lymph Disorder	yes	no	family
Cancer	yes	no	family
Diabetes	yes	no	family
Ears, Nose, Throat Conditions	yes	no	family
Gastrointestinal Conditions	yes	no	family
Heart Disease	yes	no	family
High Blood Pressure	yes	no	family
High Cholesterol	yes	no	family
Kidney Disease	yes	no	family
Lupus	yes	no	family
Neurological Conditions	yes	no	family
Psychiatric Disorder	yes	no	family
Seizures	yes	no	family
Skin Conditions	yes	no	family
Stroke	yes	no	family
Thyroid Dysfunction	yes	no	family

Current Medications (prescription and over-the-counter and dosage)

Medication Drug Allergies

Height _____ **Weight** _____

Are you pregnant or nursing? _____

Do you smoke? _____

Have you ever smoked? _____